CLAIMS
Tel: 010 020 7655
Fax: 087 942 4725
Email: claims@stangenlife.co.za

DEATH CLAIM FORM (To be completed by claimant)

SECTION A

PARTICULARS OF THE INSURED (DECEASED)

Policy Number

Surname | First Names

Title: Miss | Mrs | Mr | Dr | Prof | Initials

ID. Number

Postal Address

Postal Code

Physical Address

Postal Code

Telephone (w) | Fax (w)

Telephone (h) | Fax (h)

Cellphone

Email Address

Date of Death: Y Y Y Y M M D D

Detailed description of cause of death:

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DETAILS OF ALL DOCTORS WHO ATTENDED TO THE DECEASED DURING THE 5 YEARS PRECEDING DEATH:

C. Doctor | Address

Date attended Y Y Y Y M M D D

Hospital / Clinic | Ref. Number

B. Doctor | Address

Date attended Y Y Y Y M M D D

Hospital / Clinic | Ref. Number

A. Doctor | Address

Date attended Y Y Y Y M M D D

Hospital / Clinic | Ref. Number

MEDICAL AID DETAILS

Name of Medical Aid | Medical Aid Number

Name of Hospital | Hospital Ref. Number

Employer Name | Surname

Physical Address

Postal Code

Telephone (w) | Employee Number

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SECTION B

PARTICULARS OF THE CLAIMANT

Surname | First Names

Title: Miss | Mrs | Mr | Dr | Prof | Initials

In what capacity is this claim lodged (Beneficiary, Cessionary, Executor?) _____

ID. Number

Postal Address

Postal Code

Physical Address

Postal Code

Telephone (w) | Fax (w)

Telephone (h) | Fax (h)

Cell-phone | Communication Preference: Post | Fax | Email

Email Address

PARTICULARS OF CLAIM BY CESSIONARY

Title | Initials | Gender | First Names

Surname | Amount Claimed: R

Signature _____ | Date: Y Y Y Y M M D D

BANK DETAILS OF CLAIMANT / ESTATE

Name of Bank | Branch Name

Account Number | Branch Code

Name of Account Holder | Account Type

Signature _____ | Date: Y Y Y Y M M D D

CLAIMS
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Email: claims@stangenlife.co.za

DECLARATION AND AUTHORISATION BY THE CLAIMANT

Policy Schedule Number

Declaration

I/ we _____declare that to the best of my/our knowledge all the information that I/we have given in this claim form is accurate and complete and that I/we have not withheld any information which could influence the decision on this claim. I/we further declare that I/we understand that my/our failure to disclose relevant information in respect of this claim may invalidate the claim. I / we acknowledge that I / we fully understand the contents of this declaration.

I / we acknowledge that I / we fully understand the contents of this declaration.

Authorisation

I / we hereby authorise King Price Life Insurance Limited or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I / we further authorise King Price Life Insurance Limited or any of its representatives to release any information regarding to this claim to any other interested parties that it deems necessary in respect of this claim.

I / we warrant that I am / we are legally entitled to the proceeds under this policy and that my / our estate(s) are solvent and have not been ceded or sequestrated.

Signed _____

On _____day of _____ of 20_____